MAIN ST DENTAL CLINIC

415 MAIN ST, LILYDALE 3140
TELEPHONE: 9735 1588

DR. PETER MALIN **DR. ALEX SHEN** **DR. ANA EROR** **DR. MARIA PHAM** **DR. SARAH QUEK** **DR. LAVONNE KONG**

Welcome to Main St Dental Clinic. Please take some time to answer these questions as completely as possible. The information you provide will ensure you receive the best possible dental treatment. If you have any questions or concerns please do not hesitate in talking to any of our staff. Thank You.

PATIENT INFORMATION

Name: [Mr. Mrs. Ms. Miss. Master]_____
(Surname) (Given Names)

Preferred Name : _____ Date of Birth: _____
(If different from above)

Home Address: _____

Postal Address: _____ Postcode: _____

Telephone [Home]_____ Telephone [Mobile] _____

Who recommended you to our Dental Rooms? _____

Person responsible for fees (If different from above): _____

I UNDERSTAND THAT FEES ARE PAYABLE IN FULL AT TIME OF SERVICE AND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY PRIVATE HEALTH INSURANCE.

Signature of Responsible Party_____ Date: _____

GENERAL INFORMATION

PLEASE TICK APPROPRIATE ANSWER AND DETAIL IF NECESSARY.

Have you ever had complications either during or following dental treatment? ☐ YES ☐ NO
Details: _____

Is there a specific reason for today's visit? ☐ YES ☐ NO
Details: _____

Do you have any concerns about receiving dental treatment? ☐ YES ☐ NO
Details: _____

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PATIENT HEALTH INFORMATION

OUR AIM IS TO PROVIDE OUR PATIENTS WITH THE MOST APPROPRIATE DENTAL TREATMENT FOR THEM AND THIS CAN BE AFFECTED BY OTHER HEALTH ISSUES. PLEASE TICK APPROPRIATE ANSWER AND DETAIL IF NECESSARY.

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING?

PENICILLIN ⊡ YES ⊡ NO **CODEINE** ⊡ YES ⊡ NO **DENTAL ANAESTHETIC** ⊡ YES ⊡ NO

ASPIRIN ⊡ YES ⊡ NO **LATEX** ⊡ YES ⊡ NO **OTHER** ⊡ YES ⊡ NO

Please detail:_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? IF YES, PLEASE MARK

⊡ Heart Disease/Heart Attack	⊡ High Blood Pressure	⊡ Joint Replacement
⊡ Rheumatic Fever	⊡ Kidney Disease or Dialysis	⊡ Liver Disease
⊡ Stomach Problems/Ulcers	⊡ Diabetes Type:_____	⊡ Cancer/Tumour
⊡ Hepatitis Type:_____	⊡ AIDS or HIV antibody	⊡Blood Transfusion
⊡ Haemophilia or Anaemia	⊡ Drug Addiction	⊡ Asthma
⊡ Sexually Transmitted Disease	⊡ Epilepsy or Seizures	⊡ Depression
⊡ Sinus Trouble	⊡ Nervousness	⊡ Allergies
⊡ Dry Mouth	⊡ Bad Breath	⊡ Mouth Ulcers
⊡ Bleeding Gums	⊡ Jaw Pain	⊡ Tooth Grinding

Additional Comments:_____

_____

Do you take any drugs or medication regularly? Including herbal supplements Yes ⊡ No ⊡

Please detail:_____

_____

If female, are you pregnant? Yes ⊡ No ⊡

Who is your General Practitioner?_____ Telephone:_____

All information supplied in this form will be treated with complete professional confidentiality and discretion in accordance with any relevant privacy legislations.

A copy of our Privacy Policy is available at reception

Please check all responses, read the statement below and sign where indicated

The above information is true to the best of my knowledge. I give my consent for any treatment deemed necessary including the administering of anaesthetics, to be performed on the above named person by any of the treating dentists at this clinic.

Signed_____ Date_____